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SUBJECT: NIGERIA: BASICS II CONTRIBUTION TO CHILD SURVIVAL IN NIGERIA

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SUMMARY

¶1. Basic Support for Institutionalizing Child Survival (BASICS), both I and II, has been the flagship child survival program of USAID/Nigeria since 1993, addressing the issues of immunization, nutrition and malaria. BASICS I ended in 1999 and BASICS II became operational in 2000 in three states (Abia, Kano and Lagos) and a total of 20 local government areas (LGAs) within those states.
¶2. BASICS II was responsible for reporting on three child survival performance indicators in its target areas: Exclusive Breastfeeding (EBF) Practice; DPT3 Coverage; and Maintenance of Standard Registers in Primary Health Care facilities in their target communities. In all three categories, performance in the 20 Local Government Areas where BASICS II worked greatly exceeded the national averages, as reported in the 2003 National Demographic and Health Survey (NDHS) and, in all but one category, exceeded its own set targets for the life of the project.
¶3. The community based and led approach employed by BASICS II in its target states has been widely adopted at both federal and state levels. END SUMMARY

BACKGROUND

¶4. The BASICS II Program which ended in September 2004 began officially in Nigeria in the year 2000, following a long transition from the BASICS I Program and its work with the private sector and NGOs. Because of the new democratic regime in Nigeria, which began with the inauguration of President Obasanjo in May 1999, USAID was again able to engage with the Government of Nigeria. BASICS II introduced a new approach called CAPA (Catchment Area Planning and Action), a community based and led platform for addressing child health service delivery, but flexible enough to accommodate any issue that a community wished to address on its own. In this context, a `catchment area' is defined as the geographical area that is served by a primary health care facility.
¶5. The technical focus areas addressed by the BASICS II Project were: immunization, both routine and supplemental (polio eradication primarily); nutrition; and malaria, and the geographic reach of the Project was a total of 20 local government areas (LGAs) in three states of the federation, Abia, Kano and Lagos, with a total population of 7 million people, and a target population (children under five years of age) of 1.4 million. The current total population of Nigeria is estimated to be 130 million people, with approximately 40 million of them being under five years of age. USAID, through BASICS II, played a major role in the polio eradication initiative (PEI), being the only agency to undertake responsibility for training of the PEI personnel at all levels.

ACHIEVEMENTS

¶6. The 2003 NDHS reports a mean EBF rate for infants up to 6 months of age of 17.2% nationwide (disaggregated data by state not available). By contrast, BASICS II achieved 29% (Abia), 34% (Kano) and 36% (Lagos) EBF coverage, as reported in their 2003 Integrated Child Health Cluster Survey (ICHCS).
¶7. For full immunization coverage, the 2003 NDHS reports 13% nationwide (again, disaggregated data not available). BASICS II reported, in its 2003 ICHCS Survey, coverages of 31% (Abia), 28% (Kano) and 31%

(Lagos) for DPT3, the proxy used for full immunization coverage. BASICS II further reported that its coverage figures would have been considerably higher (i.e., demand was high), but routine antigens were consistently unavailable from the national level, causing stock outs in the primary health care (PHC) facilities.

¶8. There was no reporting of Maintenance of Standard Register (of basic health interventions for children under five in PHC facilities) in the 2003 NDHS, but BASICS II conducted a baseline survey on all its indicators at the beginning of the project. Baseline for this indicator was zero (0) for all three of their states and all 20 of the target LGAs. The importance of this register is seriously undervalued nationally, accounting for the fact that minimal data are available in Nigeria on health indicators. By working with both the national and state levels of the Government of Nigeria, BASICS II was able to supply its target PHC facilities with registers and provide training in their use. By project end, the 2003 ICHCS reported 93% (Abia), 41% (Kano) and 96% (Lagos) of facilities regularly using and maintaining standard registers.

DISCUSSION

¶9. Arguably, the most challenging state in Nigeria in which to work on health issues is Kano State, even as it is the most needful of the services (health indicators are consistently the worst in the northwest of the country and particularly in Kano State). The BASICS Program (both I and II) has been a fixture in Kano State since 1994. Because of BASICS indigenous staff and their understanding of the environment, as well as the positive working relations they have established, both at community level and with the state and local government entities, BASICS II was an accepted and important part of the Kano health delivery system. During the year long moratorium of oral polio vaccination (OPV) activity in Kano State, BASICS II remained in place, continuing its work on routine immunization (and all other child health issues) and taking a low key, but very effective, part in the advocacy necessary to resume OPV administration in the state. At one point during the height of the controversy, USAID was the only agency invited by the Kano State Government to remain working in the state. Kano rejoined the PEI effort fully in September 2004.

¶10. It was also in Kano State that BASICS II very successfully initiated the Positive Deviance/Hearth Model for rehabilitation of malnourished children. The comprehensive BASICS II approach in the challenging state of Kano was so well received, effective and doable that the Kano State Government has adopted CAPA, renamed it PLACO (Participatory Learning and Action for Community Ownership) and is providing the resources, both human and financial, to scale up statewide (44 LGAs). The Kano State Governor, the Kano State Commissioner for Health and the Kano State Primary Health Care Director have each requested that USAID continue, to the extent possible and feasible, to provide technical assistance and support for their PLACO initiative. They are also insisting that all immunization, routine and supplemental, be carried out in Kano State through the PLACO mechanism.

¶11. USAID/Nigeria also introduced, into its three target states, the concept of twice yearly Child Health Weeks as a delivery mechanism for a package of child health services, including routine immunization, vitamin A distribution, deworming, retreatment of insecticide treated bednets, etc. Because of the success of this concept in the BASICS II states, the Federal Government of Nigeria (GON) has taken the decision to adopt this program for use nationwide, making vitamin A distribution the centerpiece activity. The GON also believes that this activity will significantly boost routine immunization coverage and serve to make immunization campaigns more acceptable in certain areas.

MILLENNIUM DEVELOPMENT GOALS

¶12. Nigeria has fully joined in the effort to meet the Millennium Development Goals (MDGs) by 2015. Goal no. 4, to reduce child mortality, goal no. 5, to improve maternal health and goal no. 6, to combat HIV/AIDS, malaria and other diseases will be, in large measure, reached through child survival interventions. Child mortality will be reduced most dramatically through interventions such as routine immunization, improved nutrition (including EBF, appropriate complementary feeding of infants and young children and appropriate distribution of vitamin A and other supplements) and concentrated efforts toward the diagnosis and proper

treatment of malaria and diarrheal disease. Improved maternal health must also begin with improved nutrition, beginning long before pregnancy and continuing throughout the life cycle. Although HIV/AIDS is, at least in the short term, a stand-alone initiative, the goal of combating malaria and other diseases is part of the child survival mix through support to routine and supplemental immunization programs, promotion of malaria prevention methods and appropriate treatment for all childhood illnesses. There is a strong case to be made for the fact that nutrition is an integral part of all eight of the MDGs, and nutrition is carried out in USAID/Nigeria through child survival funding. In order to achieve these laudable goals in Nigeria by 2015, significant increases in child survival funding well above the levels now provided will be necessary from all donors and from the GON.

CONCLUSION

¶13. Child survival remains, and will forever remain, a development staple. USAID has established a strong comparative advantage and leadership for child survival programming in Nigeria. We continue to join with other donor agencies, government officials, NGOs and communities to improve the health status of children under five years of age and beyond, including the health and wellbeing of their mothers.

¶14. USAID/Nigeria, through its new implementing partner, COMPASS, will work in five states (Lagos, Kano, Bauchi, Nassarawa and the Federal Capital Territory) and a total of 50 LGAs within those five states. This expansion will greatly increase our potential reach and impact, but only with sufficient accompanying resources. Further, much of the necessary work will continue to take place at the federal levels (e.g., policy and advocacy work) and adequate funding must be provided to advance these efforts as well.

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